Safeguarding Adults Review in the case of Elizabeth

Time Period Reviewed: 1st June 2014 to Date of Death in November 2017

Final Report

Chair/Author: Maureen Noble

Contents **Page**

1. Introduction and Background

The review panel offer condolences to Elizabeth's family and friends on her sad death.

1.1 Key People

This SAR relates to the death of Elizabeth who died in November 2017. Elizabeth was in her mid-80's at the time of her death.

Elizabeth has two sons who are referred to as Son 1 and Son 2 in this report.

1.2. Circumstances leading to the review

On the evening of 12th November 2017, North West Ambulance Service (NWAS) received a call from Son 1, saying that Elizabeth was unwell and was unable to move. An ambulance attended Elizabeth's home and transferred her to hospital. **Note: In line with their policy NWAS made a safeguarding referral to Adult Social Care (ASC).** The referral contained information that described Elizabeth's condition when the ambulance crew arrived at her home. It was noted that she was in a soiled bed, unable to mobilise (Elizabeth lived in a first floor flat) and that her son was intoxicated. It was noted that the buzzer to Elizabeth's flat was disconnected.

Elizabeth was examined in hospital and was found to have fractures and bruising. She also appeared to have suffered a stroke and had an acute kidney injury.

When asked what had happened to his mother, her son stated that she fell 4-7 days ago but that medical treatment had not been sought. He reported that she had been unable to mobilise since then and had been in bed.

On the morning of 14th November, whilst Elizabeth was in hospital, police logged the referral from Adult Social Care (ASC) and noted that there had been no request for medical help following the fall.

On 15th November a strategy meeting was held which was attended by police and ASC. Information was shared regarding the home conditions found by NWAS; the presence of a number of people at Elizabeth's home, all of who appeared to be intoxicated; Elizabeth's inability to mobilize and a number of physical injuries. It was noted that there were inconsistent accounts given about what had happened over the past few days, with no clear explanation of why medical help for Elizabeth had not been sought sooner.

It was also noted that one of Elizabeth's sons had made a number of accusations about the other i.e. of financially exploiting Elizabeth, of drinking a lot and that he had removed the buzzer at the entrance to the flat. Paramedics had recorded that Elizabeth appeared nervous and shaky when in the presence of the son. When asked what had happened to her she had said she could not remember. She had not responded when she was asked if anyone had hurt her.

At 09:42 hrs on 18th November 2017, the police were contacted by Stepping Hill Hospital. Police were informed that Elizabeth had died and a request was made for police assistance to inform her son.

1.3. Background to Elizabeth

Elizabeth was described by practitioners who knew her as a strong and independent character. Elizabeth's partner died in 2010, after which she lived alone in social housing. She lived in a one-bedroomed first floor flat. It was noted by the review that Elizabeth appeared to have slept in the lounge as she became less mobile, which may have impacted her comfort.

Elizabeth had an extended family with whom she spent time. Both her sons spent time with Elizabeth during the period under review, and both appear to have spent extended periods of time living at her flat. Information provided to the review suggests that Elizabeth's sons had a turbulent relationship with each other and this appeared to result in arguments over Elizabeth's care and also in relation to managing Elizabeth's finances.

Elizabeth told her GP that she drank alcohol on a daily basis. This was a concern to her GP and other professionals who came into contact with her. Both of Elizabeth's sons were believed to drink alcohol with frequency and to excess. There are occasions on which both her sons were noted to have been intoxicated at Elizabeth's home, and both reported to professionals that the other 'drank' and 'was an alcoholic'.

Elizabeth was diagnosed with alcohol related dementia in March 2015, at which time medical advice recommended that she reduce or cease alcohol consumption. It is evident that Elizabeth continued to drink alcohol during the period under review, although she told professionals that she was reducing her intake (she also said that she did not want to stop drinking alcohol altogether).

Elizabeth experienced declining health in her older years for which she was treated by her GP. Her GP also referred Elizabeth to specialist services, however she did not attend some appointments for these services, the reasons for this are not known to the review. There are indications that Elizabeth may have been neglectful of her own health needs at times.

1.4. Time Period under Review

The period under review was agreed as being 1ST June 2014 until the date of Elizabeth's death in November 2017.

Agencies were asked to review their records and to include any significant historic contacts in their reports.

1.5. Police Investigation and Criminal Proceedings

On 28th November both of Elizabeth's sons were arrested by police for questioning in relation to her death. A police investigation was undertaken which included commissioning specialist medical reports and considering information from the Home Office pathologist.

The investigation found no evidence for a criminal case and no charges were brought against either of Elizabeth's sons. The police investigation was closed with no further action.

1.6 Coronial Matters

The Coroner was informed by letter of the commencement of the review. The date for inquest has now been set at 28th February 2019.

1.7 Family Involvement in the Review

At the commencement of the review both of Elizabeth's sons were informed in writing that a multi-agency review into agency involvement with Elizabeth was taking place. They were informed that they may be invited to participate in the review and that further contact would be made with them following the outcome of the criminal investigation.

In November 2018, the review Chair wrote to both Elizabeth's sons informing them that the review was coming to a conclusion, and inviting them to participate and/or to read the final report. At the time of writing there has been no contact from either son.

2 Conduct of the SAR

The SAR was conducted under Section 44 of the Care Act (2014) as follows:

(1) A Safeguarding Adults Board must arrange for there to be a review of a case involving an adult in its area, with needs for care and support (whether or not the local authority has been meeting those needs) if:
  (a) There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult or
  (b) Condition 1 or 2 is met

(2) Condition 1 is met if:
  (a) The adult has died, and
  (b) The SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died)

(3) Condition 2 is met if:
  (a) The adult is still alive, and
  (b) The SAB knows or suspects that the adult has experienced serious abuse or neglect

(4) A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

2.3 Terms of Reference and key lines of enquiry

The panel agreed the following terms of reference and key lines of enquiry

1. To establish what contact agencies had with Elizabeth, what services were provided to her and whether these were appropriate, timely and effective?
2. To establish whether agencies assessed Elizabeth as being at risk and what actions they took to safeguard her.
3. To establish whether Elizabeth experienced mental health issues, substance misuse or other factors that may have increased her vulnerability.

4. To establish whether organisations have appropriate policies and procedures in place to identify, refer and escalate concerns to appropriate safeguarding pathways.
5. To establish what lessons can be learned from the case about the way in which professionals and organisations carried out their duties and responsibilities.
6. To identify clearly what those lessons are, how (and within what timescales) they will be acted upon and what is expected to change as a result through the production of a multi-agency action plan.
7. To recommend to organisations any appropriate changes to such policies and procedures as may be considered appropriate in the light of this review.
8. To take into account specific issues relating to diversity.

2.3.1 Key Lines of Enquiry (Questions to be addressed agencies)

1. Did your agency know that Elizabeth was vulnerable and at potential risk of any form of abuse during in the period under review?
2. If so, what actions were taken to safeguard Elizabeth and were these actions robust and effective?
3. Did your agency know or suspect that Elizabeth was experiencing difficulties in relation to drugs, alcohol, mental health or other vulnerabilities/risk factors? If so what were these risk factors and how did your agency respond to them?
4. Did your agency identify any risk factors (including those above) that might involve members of Elizabeth's family? If so, what actions did you put in place to address these risk factors?
5. Was your agency aware of formal or informal arrangements in relation to Elizabeth's care by members of her family (e.g. Carer's Assessments, Carer's allowance)
6. Did your agency share information regarding Elizabeth in an appropriate and timely manner?
7. What multi-agency working took place in relation to Elizabeth and what were the strengths and weaknesses of multi-agency working? What could be improved or modified?
8. Was the process of safeguarding Elizabeth in relation to escalation and de-escalation from services appropriate?

2.4 The SAR Panel

The Safeguarding Adults Board appointed Maureen Noble as independent Chair and Author, to oversee the Review and to write the overview report. The Chair/Author has extensive experience in the field of public protection and community safety and significant experience in conducting Safeguarding Adults Reviews and Serious Case Reviews. The Chair/Author has also served as a member of the NICE national programme management group on domestic abuse which produced the current NICE guidance.

A SAR panel was appointed. Membership of the panel is set out below.

2.4.1. Panel Membership

Designation	Agency
Maureen Noble	Independent Chair/Author
Head of Safeguarding and Learning	Stockport MBC
Safeguarding Adults Board Manager	Stockport MBC
Detective Sergeant	Greater Manchester Police
Designated Nurse Safeguarding Adults	Stockport CCG
Named Nurse for Safeguarding	Pennine Care NHS Foundation Trust
Safeguarding Families Specialist Practitioner	Pennine Care NHS Foundation Trust
Named Nurse Adult Safeguarding and Prevent Lead	Stockport NHS Foundation Trust
Service Manager	Stockport ASC
Domestic Abuse Worker	The Prevention Alliance
Principal Social Worker	Stockport ASC

2.5 Sources of Information to the Review

The scoping exercise to determine agency involvement with Elizabeth indicated that Elizabeth had had numerous contacts with agencies, particularly as she became older. Many of these contacts related to Elizabeth's physical health. Elizabeth had also had recent contact with Mental Health Services. The panel agreed that routine contacts (for unrelated physical health issues) would not be analysed in this report.
The panel received reports from the following agencies:

Agency	Role
Clinical Commissioning Group – Short report (CCG/GP)	GP for Elizabeth
Greater Manchester Police	Police Services
Greater Manchester Fire and Rescue Service (GMFRS)	Fire and Rescue Services
Stockport Adult Social Care	Social Care Services
Central Manchester Foundation Trust (CMFT)	Provider of A&E Services

North West Ambulance Service	Emergency Service – Ambulance and Paramedic Services
Stockport Homes	Housing Provider
Stockport NHS Foundation Trust	Provider of Acute Services
Pennine Care NHS Foundation Trust	Provider of Mental Health Services

2.6 Practitioner Involvement in the Review

A practitioner learning event was held in September 2018, which was attended by practitioners, who had had direct contact with Elizabeth and her family, and by service managers. The views of practitioners are included as appropriate throughout this report.

3 Contact with Agencies (Condensed Chronology) and Key Practice Episodes

Key to Social Workers

SW1	**June 2014 to September 2014 and April 2016 to July 2017**
SW2	**November 2014 to July 2017**
SW3	**November 2017 to date of death**

The condensed chronology sets out key contacts with Elizabeth during the period under review. Key episodes of practice are highlighted in bold.

Elizabeth had a large number of contacts with medical services due to health conditions, not all of these contacts have direct relevance to the review and are not included in the condensed chronology.

3.1 Events in the period 1st June – 31st December 2014

On 17th June 2014, Elizabeth was visited at home by her GP. It was noted that Elizabeth had mild cognitive dysfunction. She was asked about alcohol consumption and said that she was drinking one bottle of wine a day.

Key Practice Episode 1: *On 25th June 2014, ASC raised a safeguarding alert following a report from Elizabeth's bank regarding concerns that Elizabeth's sons were using her bank*

cards and that direct debits were going unpaid. The alert was progressed through the ASC system, with an officer attempting to contact Elizabeth by phone on 26th June 2014, to discuss this with her, there was no reply and a voice message was left for Elizabeth to make contact (there is no record of this call in the ASC records).

On 26th June 2014, Stockport Homes raised concerns to ASC regarding potential financial mismanagement, reporting that Elizabeth had a large amount of arrears on her tenancy. On 27th June the case was allocated to SW1.

On 9th July 2014, it was agreed that a strategy meeting should take place as there had been no response from Elizabeth or either of her sons. A 'virtual' strategy meeting took place on 10th July 2014, the outcomes of which were for SW1 to contact Elizabeth, to make contact with the police and to obtain consent to discuss the matter with Elizabeth's sons.

On 18th July 2014, SW1 made a home visit to Elizabeth and was initially denied access to the house. Elizabeth said she did not want any involvement with ASC. However, Elizabeth then allowed SW1 into her home and discussed the issues raised regarding concerns about financial management. Elizabeth said that there was nothing untoward in relation to her sons' involvement in her finances, although she did acknowledge that money was going missing. However, she said that her sons were not to blame for this. Elizabeth said that she did not want police involvement, but said that she would allow the matter to be discussed with her sons. SW1 deemed that Elizabeth had capacity to make decisions.

On 25th July 2014, SW1 closed the safeguarding concern based on the assessment of Elizabeth's capacity to make decisions. That same day SW1 tried to contact Elizabeth's son by phone to discuss the concerns raised, but was unable to speak to him. A further attempt at telephone contact was made on 6th August 2014, again without success.

Analysis of Practice KPE 1
Although enquiries were made into Elizabeth's finances, the gravity of the concerns expressed by Elizabeth's bank were not assessed objectively by any agency.

SW1 spoke to Elizabeth regarding the allegations, however, there is no indication that this took into account that Elizabeth may have been vulnerable to coercion or manipulation by her sons. Elizabeth's assurances were taken at face value.

It is not clear whether the capacity assessment was conducted in line with Mental Capacity Act standards.

On 13th August 2014, ASC held a phone discussion with Stockport Homes regarding Elizabeth's tenancy, which was at risk due to rent arrears. The following day SW1 spoke to Son 1 who said he was aware of the problem and agreed with professionals that actions needed to be put in place. He said that Son 2 was responsible for the financial mismanagement of Elizabeth's affairs.

On 21st August 2014, Elizabeth received a home visit from a paramedic following a concern for her health, which had been raised by her home care provider. She said was experiencing chest pain. On examination this was found to be muscular pain and a notification was sent to her GP. The following day the GP reviewed Elizabeth's medication and gave verbal advice regarding alcohol consumption.

On 15th August 2014, Son 2 contacted SW1 to say that he had been to the bank with Elizabeth and cancelled the bank card to prevent any further misuse. Son 1 was granted third party access to Elizabeth's account. Son 2 said he would notify police as they were 'coming round next week'.

On 3rd November 2014, a referral was received by the ASC Contact Centre from Son 2. He said he had been staying with Elizabeth for six weeks and had noticed a decline in her memory and personal care. Elizabeth had given verbal consent for the contact. The referral was screened by an ASC Assistant Team Manager, who allocated it to SW2.

On 1st December 2014, SW2 completed a home visit at which Son 2 was present. SW2 identified concerns in relation to alcohol consumption and that Elizabeth was not consistently taking her medication. Some carer stress was identified by SW2 and Son 2 was spoken to about reducing his contact with Elizabeth to alleviate this. A package of home care was offered to assist Son 2, however Elizabeth said she did not want this.

On 3rd December 2014, SW2 contacted the GP to raise concerns about Elizabeth not taking her prescribed medication. The GP advised that the majority of prescribing was for vitamins, which were prescribed to counter-balance Elizabeth's alcohol intake and poor nutrition. The GP advised that Elizabeth would not be at high risk of harm if she did not take the medication prescribed.

Following a discussion with the GP, SW2 made a number of referrals including a referral to the Community Mental Health Liaison Team (CMHLT). SW2 also initiated a benefits check and sent information to Son 2 regarding appointee ship from the Department for Work and Pensions (DWP).

CMHLT received the referral and contacted the GP on 4th December 2014 for a list of Elizabeth's prescribed medication, which was faxed to them.

On 11th December 2014, Greater Manchester Fire and Rescue Service (GMFRS) received a request from SW2 to undertake a safety check[1] at Elizabeth's home. The assessment took place on 6th January 2015.

On 23rd December 2014, SW2 conducted an assessment with Elizabeth to review any risks of harm. The assessment included discussion about Son 2 pursuing formal appointee ship. A

[1] **This is a local service provided as an additional measure to safeguard vulnerable people.**

support plan was agreed in which it was recorded that Elizabeth wished to maintain as much of her independence as possible. Elizabeth's alcohol consumption was discussed and Elizabeth said that she did not want to stop drinking alcohol. The plan included a reminder that Elizabeth should be encouraged to take her medication.

On 30th December 2014, Elizabeth was seen for assessment at her home by a nurse from CMHLT at which Son 2 was present. The assessment included discussion with Elizabeth regarding her alcohol intake and issues around memory loss. Elizabeth was noted in the assessment to have insight into her alcohol consumption.

Elizabeth engaged with the assessment. The nurse noted that there was some evidence of cognitive impairment and the assessment concluded that Elizabeth had a mild mental health problem (using the threshold assessment grid).[2]

3.2 Events in the period 1st January – 31st December 2015

On 5th January 2015, it was noted in the ASC records that a Home Care provider (Quality Care) had been sourced for Elizabeth and was due to start on 7th January 2015.

On 6th January 2015, GMFRS visited Elizabeth's home to conduct a safety check (as referred to above). SW2 and one of Elizabeth's sons were present.

On 8th January 2015, CMHLT conducted a follow up visit to Elizabeth at home. Elizabeth was alone and was noted to be open to the assessment and demonstrated warmth. Elizabeth said that she felt lonely and isolated. Options regarding support were discussed. Elizabeth said that she had stopped drinking alcohol. A cognitive assessment was completed and Elizabeth's recall was noted to be poor. The CMHLT nurse planned to speak to Elizabeth's social worker regarding further interventions in relation to Elizabeth's memory problems.

On 16th January 2015, Elizabeth's GP received a notification from Age UK that Elizabeth had fallen, although the cause of the fall was not known. The GP gave advice regarding avoiding falls, and practical options were offered, although Elizabeth did not wish to take all of these up.

On 19th January 2015, SW2 documented a discussion with Son 2 in relation to a request for a reduction in the number of home care visits. SW2 said it should be noted that reducing the number of visits may put Elizabeth at greater risk.

This was followed by a home visit by SW2 on 21st January 2015, at which Son 2 was present. Ongoing issues such as alcohol intake, loneliness and risk of falls were discussed. Son 2 said that Elizabeth had changed her alcohol consumption and was drinking wine instead of whisky, and he felt that this was a positive change. It was also noted that there was

continuing poor compliance with medication. Son 2 said he was seeking appointee ship and this was encouraged by SW2.

On 23rd January 2015, Elizabeth's home care support plan was revised to include supervision of meals and medication, but with a reduction to two days home care rather than three. Son 2 said that he would visit Elizabeth on the other days.

On 11th February 2015, SW2 undertook a scheduled review visit at which it was noted that the overall situation for Elizabeth appeared to have improved. It was noted that Son 1 had visited a number of times, but Elizabeth did not express that she had any concerns about this. There was agreement that, due to overall improvements, there was no longer a need for social care involvement and the case was closed with a note to review annually.

On 23rd February 2015, as part of case closure process, SW2 conducted a formal risk assessment. The risks identified were Elizabeth's stated ongoing wish to consume alcohol and possible financial impropriety by Son 1. It was noted that Son 2 was pursuing appointee ship and that DWP would be informed that the case was now closed to ASC. On the same day, Elizabeth and Son 2 were formally notified of case closure.

On 25th February 2015, Elizabeth's GP conducted a home visit following a report that Elizabeth had fallen. Elizabeth was examined and found to have bruising to her arm. It was unclear when the fall had taken place. The GP discussed with Elizabeth that she should reduce her alcohol intake. Advice was given and paracetamol prescribed. A district nurse visited two days later to check bloods.

On 2nd March 2015, Pennine Care conducted a memory assessment at home with Elizabeth. Elizabeth was assessed as having mild cognitive impairment. Son 2 was present at the assessment. It was noted that there were no psychiatric aspects to Elizabeth's cognitive impairment, and that a reduction in alcohol consumption may result in an improvement in Elizabeth's memory. It was noted that the clinician's opinion was that that it was unlikely that Elizabeth would stop drinking alcohol altogether given that she had already said that she wished to continue.

Key Practice Episode 2: *On 20th March 2015 ASC screened a safeguarding alert they had received from the Home Care agency, in which they expressed concern that Elizabeth's medication had been tampered with. The alert made reference to Son 2's use of alcohol, which was previously unknown to ASC. Following screening, the referral was closed to safeguarding and a note made that a review of the case was required.*

On 27th March 2015, a further safeguarding alert was screened, again from Elizabeth's Homecare Agency. They had received a letter requesting immediate cessation of Elizabeth's care package. The letter purported to be from Elizabeth, but was not in her handwriting and was countersigned by Son 1. This alert was closed down to safeguarding with a further note that a full review should be conducted.

Analysis of Practice KPE 2

The first safeguarding alert was an indication that risks had increased following the recent case closure and warranted further investigation, although it was noted that the case required review.

It would have been good practice for the new information regarding Son 2's alcohol use to have led to further consideration of the appropriateness of him applying for appointee ship.

The second safeguarding alert was an indication that concerns were escalating. It would have been good practice if ASC had recognised and acted upon this. No contact was made with Elizabeth following this alert and this was a missed opportunity to explore safeguarding with her.

On 31st March 2015, the GP noted a conversation held with SW2 that Elizabeth was refusing support and that home care was likely to be cancelled. Elizabeth had said she had capacity to look after herself and that she was receiving support from her son

SW2 spoke to Elizabeth and Son 2 on the phone regarding the request for cancellation of the care package. Following this, the care package was cancelled and SW2 planned a visit to see Elizabeth at home the following day. On 1st April 2015, SW2 telephoned regarding a home visit, however, Son 2 said that he and Elizabeth would be out.

SW2 tried to visit Elizabeth at home on 7th April 2015, but could not get any answer. SW2 later spoke to Son 2 who said that he and Elizabeth had been asleep when SW2 had visited. SW2 tried to contact Son 1 by telephone, but could not get any answer. A further appointment was arranged for 9th April 2015.

On 7th April 2015, ASC received a letter confirming the outcome of the psychiatric assessment undertaken with Elizabeth. This confirmed a diagnosis of alcohol related dementia. The advice to Elizabeth was to cease alcohol consumption, although the psychiatrist felt that it was unlikely that this would happen. No further treatment or assessments were planned.

On 8th April 2015, the visit by SW2 planned for 9th April 2015, was cancelled by Son 2. A new appointment was arranged for 10th April 2015, which went ahead with Elizabeth and Son 2 present. Both Elizabeth and Son 2 said that they wanted to cancel the care package as it was not worth the cost. Elizabeth said that she was capable of independent living. SW2 agreed to the cancellation of the home care package but expressed concern (and later communicated this to the GP) about Elizabeth's ability to manage without home care.

On 15th April 2015, the GP received formal notification from SW2 of the cancellation of the care package and of SW2's concerns about this.

On 30th April 2015, the GP received notification of discharge from CMHLT asking the GP to monitor and refer back if necessary.

On 14th May 2015, the GP surgery received a call from Son 2 saying that Elizabeth was confused and requesting assistance. The line was cut off by the caller and the GP tried to call back, however there was no reply. The GP visited Elizabeth's home later that afternoon/evening but could get no reply. This was good practice by the GP. A neighbour said that Elizabeth and Son 2 had left the house 10 minutes ago and that they thought they may be going to A&E.

Key Practice Episode 3: *On 29th May 2015, police received a call from Son 2 saying that Son 1 was drunk and was being verbally aggressive to him and had also pushed their mother Elizabeth. Police officers attended Elizabeth's address and found all those present to be intoxicated. Elizabeth said that there had only been a verbal argument. Police advised Son 1 that he should leave the premises, which he did. The attending officer assessed the incident as being a family argument in which alcohol had been an influencing factor, and that no crime had taken place. The incident was assessed and recorded as standard risk.*

Analysis of Practice KPE 3
This was a missed opportunity to make a referral to ASC for Elizabeth as an adult at risk. Although the risk is recorded by police as 'standard' there is no indication of how the level of risk was assessed.

In the early hours of 30th May 2015, Son 1's former partner rang police to report that he had turned up at her home. She said he was intoxicated and was banging on the door asking for keys to his house. He was given the keys, he returned later and was reported to be causing a disturbance outside the house. Police attended, however, Son 1 had left the property before they arrived. The complainant said was aware that Son 1 had been ejected from his mother's house earlier. Police assessed the risk as standard.

On 9th July 2015, following a visit for medical reasons, the nurse rang SW2 to update on Elizabeth's medical needs. **(Note: This contact is included in the report as it demonstrates good practice in inter-agency working and communication).**

On 15th July 2015, SW2 wrote to the GP to advise of the cessation of the care package and that Elizabeth capacity had been assessed. It was noted that SW2 remained concerned regarding Elizabeth's understanding of the need to take medication regularly. Arrangements were made with the pharmacy to deliver medication in future.

Between July 2015 and April 2016, a number of contacts took place with GP and other health professionals for medical interventions that are not related to this review.

3.3 Events in the period 1st January – 31st December 2016

Key Practice Episode 4: *On 15th April 2016, ASC received a safeguarding alert from Stockport Homes, regarding a request received via Son 1 to complete a 'Right to Buy' purchase of Elizabeth's flat. The alert was raised following Son 1 being reluctant to allow Elizabeth to discuss the application. Stockport Homes insisted that they must speak to Elizabeth regarding the request. When they did so Elizabeth appeared confused and Stockport Homes were concerned that she was being 'coached' by Son 1 in what to say. They placed a hold on the application pending discussion with ASC.*

Analysis of Practice KPE 4
It was good practice for Stockport Homes to raise a safeguarding alert. However, an opportunity was missed by ASC to speak to Elizabeth about the concerns. It would have been good practice to hold a multi-agency conversation to reassess Elizabeth's circumstances and potential risks before closing the safeguarding alert.

The risks to Elizabeth were ongoing as allegations had been made by Son 1 about Son 2 taking money from Elizabeth. There is no apparent consideration of the on-going risks to Elizabeth documented in the closure of the safeguarding alert.

On 18th April 2016, a Debt Recovery Officer from Stockport MBC provided information that Elizabeth had debts relating to her previous care package. She had spoken to Son 2 about this and he had said that Son 1 had been financially abusing Elizabeth and that the accounts were empty.

On 22nd April 2016, SW1 (who had now been reallocated the case) spoke with Stockport Homes who said they had written to Son 1 regarding cancellation of the 'Right to Buy' application if they did not hear from him. SW1 arranged to visit Elizabeth on 5th May 2016 (she noted at this time that Son 1 was reportedly living in another country).

On 5th May 2016, Son 2 rang ASC to report that Son 1 was now back in the country and that he was staying with Elizabeth. Son 2 said that Elizabeth had said she didn't want him to stay with her now that Son 1 was back. ASC decided not to go ahead with the visit as Son 1 had now returned.

On 6th May 2016, a discussion took place between SW1 and the Assistant Team Manager about the long history of allegations of financial impropriety between the brothers, and it was deemed that an urgent investigation was not required, and that matters could wait until the following week.

This safeguarding alert was closed down on 6th May 2016, as the right to buy request had been halted and it was judged by ASC that any risk had passed

On 25th May 2016, SW1 undertook a home visit at which Son 1 was present. SW1 noted that Elizabeth was dressed well and appeared to be in good spirits and healthy. Son 1 said that he was staying with Elizabeth until September, when he would be returning to another country to get married. He said that he intended to return to England after his marriage, and that Elizabeth could then come to live with him.

At the visit, Son 1 said that he had concerns that Son 2 was an alcoholic who had fed his mother alcohol and had taken money from her. He said he was concerned that, when he went abroad, Son 2 would begin to take advantage of Elizabeth again in relation to her money. This was noted by SW1 for discussion with the Team Manager.

On 6th June 2016, police received a call from Son 1 saying that Son 2 had stolen his passport. He said that Son 2 was a chronic alcoholic who had taken money from their mother. Police went out to speak to Son 1 who then refused to substantiate either allegation. Police could therefore take no further action.

On 23rd June 2016, at a meeting between SW1 and the Assistant Team Manager, it was decided that there was no firm evidence of financial abuse, that Elizabeth appeared to be well cared for and that she retained capacity. It was agreed that SW1 would monitor the situation and close the case if there were no further concerns raised in the next two weeks.

On 3rd July 2016, Son 1 telephoned the ASC contact centre to say that Son 2 had been taking money from Elizabeth and had been buying her alcohol (and that Son 2 was also using drugs). Son 1 said that there was no food in the house and that there was no money to buy anything. The call taker spoke directly to Elizabeth, who said that Son 1 was wonderful, and that Son 2 was 'twisting' her. The call taker made a note for SW1 to note Son 1's reported concerns.

On 6th July 2016, police received a call from Son 1 saying that Son 2 had threatened to kill him after he had stolen his mother's pension. The threats took place over the phone. Police investigated the allegation with Son 1 who said that he had been intoxicated when he rang the police, and that he did not wish to take the matter further. A visit took place by STRIVE who noted that Elizabeth had said she was happy with Son 1 living with her and had no concerns.

Key Practice Episode 5: *A safeguarding alert was received on 12th July 2016, from the STRIVE team who had become involved due to disputes between Son 1 and Son 2 in relation to Elizabeth's finances. The team had visited Elizabeth's home and found conditions to be poor, Elizabeth to be confused and indications that Elizabeth's sons were drinking heavily. There were inconsistences in the accounts given by Elizabeth's sons about their involvement in her finances.*

The safeguarding alert was closed down following discussion with the Team Manager with a note put on file that there was a 'historical dynamic' of money being borrowed within the family.

A further Safeguarding Alert was received from Stockport MBC's debt recovery team, who had been involved in relation to unpaid council tax and an outstanding balance on Elizabeth's Social Care account (from her previous period of having a package of care). In attempting to recover these debts, they had received allegations from Son 2 that Son 1 had been taking money from Elizabeth and that this was the reason for the debts going unpaid.

Analysis of Practice KPE 5
These safeguarding alerts were not progressed through the Safeguarding Adults process. The plan instead was for a social work intervention to attempt to engage with Elizabeth and her sons. The purpose of the intervention was to establish what could be done to assure appropriate management of Elizabeth's finances. This was a missed opportunity to view Elizabeth as a potential victim of coercion and control.

It would have been good practice to hold a multi-agency discussion to assess ongoing risks to Elizabeth in light of the assessment of risk made by the STRIVE team.

Ultimately none of the Safeguarding Alerts received during this period of intervention were progressed through formal safeguarding procedures.

On 23rd June 2016, a discussion took place with the Assistant Team Manager in ASC, in which it was recorded that there were no clear signs of financial abuse.

At this time, Elizabeth instructed ASC to deal with Son 1 rather than Son 2. With some noted difficulties, the SW1 attempted to engage with Elizabeth and Son 1, along with an officer from Stockport MBC's debt recovery section. Information provided by Son 1 suggested that Son 2's appointee ship had been brought to an end by the DWP.

The intervention ended with SW1 undertaking a formal assessment of Elizabeth's capacity[3] to make the decision for Son 1 to have access to her money. Having judged that Elizabeth had the capacity to make this decision, the case was once again closed to ASC.

On 3rd August 2016, the GP noted a telephone contact from SW1 regarding concerns about Elizabeth's memory loss and possible financial mismanagement.

During the course of the next week, SW1 tried on several occasions to contact Son 1, regarding the allegations he had made about Son 2 financially abusing Elizabeth.

On 5th August 2016, SW1 had a conversation with Elizabeth's GP in which the diagnosis of dementia was discussed. SW1 asked the GP to record concerns regarding possible financial impropriety by Elizabeth's sons.

On 31st August 2016, an officer from DWP spoke to a member of the ASC team (SW1 was on leave). The officer advised that she had visited Elizabeth and noted that, whilst Son 2 has appointee ship (this was not correct as appointee ship had not been formalised) Son 1 had alleged that Son 2 was spending Elizabeth's money on drugs. The information was noted to be passed on to SW1 on her return.

On 2nd September 2016, SW1 and an officer from the MBC Debt Recovery service visited Elizabeth at home. Son 1 was present. He again alleged that Son 2 was financially abusing Elizabeth and provided bank statements to show cash withdrawals from Elizabeth's account. He said that Son 2 did not have appointee ship for Elizabeth. SW1 discussed matters with the Assistant Team Manager and made a note to follow up with Elizabeth to gauge her response.

On 14th September 2016, the GP received a letter from Son 1 describing himself as Elizabeth's carer. In the letter, he said that Elizabeth could not look after her own basic needs and that she was on a low income but still paying full council tax. Son 1 requested that the GP endorse an application in regard to lowering council tax. The GP felt it was inappropriate to endorse the application and refused to do so.

On 29th September 2016, the GP conducted a home visit to Elizabeth to review her medical condition. She was alone at this visit. She said her son was looking after her, she presented as settled and orientated and expressed no complaints or concerns.

On 5th October 2016, SW1 conducted a mental capacity assessment with Elizabeth. The specific decision being explored was whether Elizabeth had capacity to grant Son 1 access to her bank account and withdraw money. The assessment concluded that Elizabeth had the capacity to make this decision. Following the assessment SW1, discussed the outcome with her manager and the case was closed.

3.4 Events in the period 1st January 2017 to date of Elizabeth's death

On 1st February 2017, ASC received a Safeguarding Alert from Son 2 in which he alleged that his brother was out of the country and that he was in possession of Elizabeth's bank card and had been taking money without consent from Elizabeth. Son 2 said he had taken immediate steps to have the card cancelled by the bank. The report was dealt with over the telephone, and the investigation was filed as it was deemed that there was no evidence to support the allegation that money had been withdrawn.

On 6th February 2017, Elizabeth confirmed that ASC should remove Son 1 as a contact and that all contact should be with Son 2. She said that Son 2 was 'the good son'.

Key Practice Episode 6: *On 7th February 2017, a safeguarding referral was received by ASC. Son 2 had contacted them to say that bailiffs were at Elizabeth's property and attempting to remove furniture in relation to a debt accrued by Son 1 who was out of the country. ASC contacted the bailiffs and had the debt removed.*

On 14th February 2017, the case was re-opened to SW1. SW1 discussed the allegations and counter allegations about financial impropriety with Son 2 and noted that it was difficult to see what could be done. She advised that Son 2 should discuss matters with Son 1.

On 21st March 2017, police received a call from Son 1, in which it was noted that he was very intoxicated. He alleged that Son 2 had tried to kill him. Police spoke to Elizabeth at her home later that day. The incident was closed with no exploration of Elizabeth's safety. No vulnerable adult referral was made.

On 22nd March 2017, SW1 discussed the case with her manager. SW1 discussed options for addressing these concerns with her supervisor and explored options to support Elizabeth in management her finances, but these were ruled out. It was agreed that there were no available options to assist with the difficulties about financial management.

The safeguarding alert was closed down with a plan for SW1 to revisit Elizabeth for a discussion to see whether she wished to accept support. At the visit, Elizabeth said that she knew both her sons had access to her money but said she didn't want any intervention. A decision was therefore made to close the case.

Analysis of Practice KPE 6
The Social Worker raised the issues with Son 2 and explained that this was the latest in a long line of allegations between him and his brother. This was good practice, however, it did not result in any specific change in the situation as the responsibility for resolving issues was left with the two sons.

In light of the significant safeguarding background to the case, the Debt Management Service may have been able to assist, particularly if approached under a formal Safeguarding process. A Solicitor taking on Lasting Power of Attorney for Finance and Property was also discussed, but ruled out on the grounds that without a large income and debts to service, a solicitor would not take on the case as they would not be paid for their work.

The outcome of this discussion, similar to previous such discussions was that the safeguarding alert be closed down. It is not evident that sufficient consideration was given to indicators of possible abuse without speaking to Elizabeth to get an up to date view of her wishes and capacity. It would have been good practice to hold a multi-agency discussion to assess risk and consider options of support for Elizabeth at this time.

On 6th April 2017, SW1 spoke to Son 2 who informed her that Son 1 was now living with Elizabeth. He alleged that Son 1 was financially abusing Elizabeth but that he was reluctant to visit Elizabeth at home because he ended up fighting with his brother.

On 28th April 2017, SW1 spoke to Elizabeth about the allegations of financial mismanagement. Elizabeth said that she knew that her sons had access to her money but she did not want to do anything about it. SW1 said that there were conflicting accounts coming from both sons about Elizabeth's money. SW1 spoke to her manager regarding the case, they agreed that there was an ongoing family dynamic about finances and a decision was made to close the case.

On 11th June 2017, Son 2 rang police to report that he was concerned about Son 1 as he had not returned home after being in the pub the previous day. He reported that Son 1 was suffering from depression. Son 1 later contacted police to say that he was safe and well, but that he thought his drink had been spiked.

On 1st August 2017, Elizabeth was visited at home by the GP for an annual dementia review. At this visit Elizabeth said that Son 1 lived with her and that he was her carer. Over the next four days, the GP surgery had contact with Elizabeth regarding an unconnected medical issue. The GP tried to speak to Son 1 on the phone but was unable to reach him.

Over the next three weeks, Elizabeth missed several appointments for an important health assessment.

On 21st September 2017, one of Elizabeth's sons rang the GP to say that Elizabeth was not well and was in pain. He said that she had not wanted to attend the appointments that had been arranged for her.

Key Practice Episode 7: *On 30th October the Practice Nurse (PN) who saw Elizabeth approximately every six months, raised a concern via telephone to the ASC Contact Centre. She reported that she had visited Elizabeth and that Elizabeth looked unkempt and appeared neglected.*

The PN said she understood that Son 1 was in receipt of carers allowance for Elizabeth (although this was incorrect), but that he appeared to be out of the country. Son 2 was staying with Elizabeth and had made allegations of financial mismanagement by Son 1

The PN was concerned about the home conditions and Elizabeth's physical presentation. She was also concerned that the wire to the intercom at Elizabeth's home had been disconnected (Son 2 alleged that Son 1 had done this because people were pursuing him for debts).

A SW in the Crisis Response Team screened/triaged the information and determined that, as Elizabeth was not at risk of hospital admission within 24 hours (the criteria for immediate response), the referral should be passed to the neighbourhood team the following day.

The following day the safeguarding alert was passed to the local Integrated Neighbourhood team and was screened by the Assistant Team Manager, who judged that the case needed

urgent allocation for a Level 3 Social Worker to see Elizabeth, however no follow up was actioned that day.

Analysis of Practice KPE 7
The events that followed the contact from the Practice Nurse on 30th October 2017, clearly give rise to questions as to whether this safeguarding alert was handled correctly.

The Assistant Team Manager has reflected that it would have been expected practice to have asked the duty Social Worker to make contact with Elizabeth and to have visited Elizabeth that day to assess the immediate situation.

Factors contributing to the case not being allocated were identified as (i) a high volume of cases being screened each day (high levels of neglect/self-neglect are reported to the team); (ii) judgment regarding the history of previous safeguarding alerts in relation to financial concerns and them being closed down quickly; (iii) historical incidents links with the current situation not being apparent without deeper investigation.

It would be speculative to suggest that a quicker response would have impacted the eventual outcome of the case, however, it would have led to some form of support being made available to Elizabeth more quickly.

The practice in this episode was not consistent with the standards set out in the Stockport Multi-Agency Safeguarding Policy and Procedure.

Elizabeth was allocated to SW3 on 7th November 2017, (a non-working day for the SW concerned) the following day SW3 undertook a number of actions, including contacting the Practice Nurse about her concerns. She also discussed the case with the previous SW to gather some background information. SW3 also contacted Son 2 at Elizabeth's address to arrange an initial visit. This was planned for 14th November (by which time Elizabeth had been admitted to hospital).

Key Practice Episode 8: *ASC received notification that Elizabeth had been admitted to hospital on 12th November 2017, and Safeguarding Alerts were sent to the hospital Social Work Team from both NWAS and the Emergency Department at Stepping Hill Hospital due to concerns about Elizabeth's condition.*

It was noted in the alerts that Elizabeth was reported to have fallen 4 days previously without anybody seeking medical advice. The ambulance crew also raised that both Son 1 and Son 2 were at the property with other family members, all of whom appeared to be intoxicated.

The ambulance crew noted that Elizabeth was found to be in a soiled bed, clearly distressed and in pain and appeared nervous when Son 1 approached her.

Analysis of Practice KPE 8
These safeguarding alerts were progressed in line with expected practice standards with a Strategy meeting being held on 15th November. At the strategy meeting the decision was

made that, due to the nature of the concerns/allegations the police would lead on the investigation.

Elizabeth was admitted to Stepping Hill Hospital on 12th November 2017, with Safeguarding Alerts being made by both the North West Ambulance Service (NWAS) and the Emergency Department at Stepping Hill Hospital.

These alerts were taken through referral, into strategy meeting by a Team Manager on the Integrated Transfer Team (Hospital Social Work) with an initial Strategy meeting being held at Stepping Hill Hospital 15th November 2017.

On 18th November 2017, ASC received notification that Elizabeth had died and the decision was taken to cancel the next Safeguarding meeting because the Police had taken over the investigation.

Greater Manchester Police were identified as the lead agency for the investigation given the nature and scale of the allegations being made. Elizabeth sadly died on 18th November 2017.

It was later confirmed that further work under Safeguarding would not be required as the Police investigation was now looking into the cause of Elizabeth's death.

4. What has been learnt from the review?

4.1 Addressing the Key Lines of Enquiry and key practice episodes

4.1.1. Did agencies know or suspect that Elizabeth was subject to any form of abuse (domestic abuse, intergenerational abuse, financial abuse, coercion and control) at any time during in the period under review?

There is no evidence that Elizabeth was subject to physical abuse or wilful neglect during the period under review.

On numerous occasions, concerns were raised by agencies regarding financial impropriety in the form of shared information between agencies, safeguarding alerts and allegations made by Elizabeth's sons (that each was responsible for exploiting Elizabeth).

Elizabeth appeared unwilling or unable to accept that she may have been subject to financial exploitation and opportunities were missed to support Elizabeth in discussing her concerns.

Capacity assessments were used to determine whether Elizabeth's decision making about her finances was sound. However, it would have been beneficial to explore whether Elizabeth was subject to coercion and control and whether this might have influenced her decision making.

4.1.2. If so, what actions were taken to safeguard Elizabeth and were these actions robust and effective?

Action to safeguard Elizabeth from financial impropriety was inconsistent and ineffective due to a lack of consideration of coercive and controlling behaviour as a factor in her decision making.

4.1.3. Did agencies know or suspect that Elizabeth was experiencing difficulties in relation to drugs, alcohol, mental health or other vulnerabilities/risk factors? If so what were these risk factors and how did your agency respond to them?

Elizabeth was diagnosed with alcohol related dementia and experienced some cognitive impairment as a result.

Elizabeth was advised to reduce her drinking, or preferably abstain and advised that some of the effects on her cognition may be reversible. Elizabeth however said that she did not want to stop drinking alcohol altogether. One of Elizabeth's sons tried to assist in reducing Elizabeth's alcohol consumption.

Professionals provided appropriate advice to Elizabeth to manage alcohol use and the GP prescribed supplements to enhance Elizabeth's nutrition. Good practice by professionals was evident.

There are indications that Elizabeth was sometimes neglectful of her own needs. The review suggests that professional understanding of self-neglect and responses could be strengthened

4.1.4. Did agencies identify any risk factors (including those above) that might involve members of Elizabeth's family? If so, what actions were put in place to address these risk factors?

The review concluded that agencies were aware that Elizabeth's sons had a turbulent relationship with each other and that both sons sometimes consumed alcohol to excess. Professionals were also aware that both sons stayed with Elizabeth, sometimes for long periods of time, although they were not tenants at Elizabeth's property.

There was a lack of professional curiosity about potential risks to Elizabeth resulting from her sons being intoxicated when staying with her and acting as her carers.

As set out above, there were several occasions on which professionals raised concerns about issues of financial mismanagement which led to a number of safeguarding alerts. However, there was a lack of co-ordinated single and multi-agency action to address the ongoing allegations of financial impropriety and to fully assess whether Elizabeth was subject to coercive and controlling behaviour by her sons in relation to financial matters.

4.1.5. Were agencies aware of formal or informal arrangements in relation to Elizabeth's care by members of her family (e.g. Carer's Assessments, Carer's allowance)?

Elizabeth's sons referred to themselves on occasion as her carers. However, neither son appears to have been offered a carer's assessment. There is no record of either son having received carer's allowance.

An early assessment of Elizabeth by SW1, at which Son 2 was present, identified that he was experiencing some carer stress and it was suggested that he reduce the amount of direct care he was providing. It is not evident that a carer's assessment was pursued either by SW1 or Son 2.

4.1.6. Did agencies share information regarding Elizabeth in an appropriate and timely manner?

Information sharing between agencies was of variable consistency and quality. There are many examples of social care sharing information with GP, the housing provider and the benefits assessor. Effective communication between the GP and Practice Nurse is also evident. Police contacted ASC in relation to incidents involving Elizabeth's sons, however there is no evidence of a safeguarding adult referral taking place when police attended an incident at Elizabeth's home.

There is no evidence of a coordinated approach to information sharing and no evidence of multi-agency meetings or consistent systems of communication across agencies. This is particularly apparent in relation to multi-agency working to support Elizabeth. A stronger focus on multi-agency working would have strengthened understanding of Elizabeth's daily lived experience and enabled a more robust approach to safeguarding Elizabeth.

4.1.7. What multi-agency working took place in relation to Elizabeth? What were the strengths and weaknesses of multi-agency working? What could be improved or modified?

As set out above, communication between single agencies was of variable quality and consistency, however there are examples of cross agency information sharing (e.g. between the GP and ASC).

A stronger focus on multi-agency co-ordination and decision making would have brought information together in relation to safeguarding Elizabeth, and would have strengthened understanding and responses to the complexities within the case.

The use of professional meetings and conversations would have enabled professionals across services to discuss Elizabeth's needs and risks and to jointly manage these.

4.1.8. Was the process of safeguarding Elizabeth in relation to escalation and de-escalation from services appropriate?

It is evident that the process of safeguarding Elizabeth in relation to escalation and de-escalation from services fell below the expected standards. This is explored in more detail throughout the report and in the conclusions and recommendations section.

4.2 Changes to the System since the period under review

4.2.1 Multi-disciplinary working

Neighbourhood services now operate a model where multi-agency working is at the heart of complex cases. Although these models were in development during the period under review, they are now established and embedded into practice.

Neighbourhood teams consisting of ASC, District Nursing, Third Sector organisations and health partner (including GPs, mental health liaison practitioners and others) are now co-located which affords greater opportunities to work together and share information in real time.

There is a new liaison forum between the neighbourhood team and housing. This would have been a forum in which a case such as this would have been discussed.

4.2.2. Referral and Assessment

ASC is about to embark on a significant redesign of its 'front door' to ensure greater professional presence at the first point of contact. The aim is to ensure that the public and professionals get the right advice, information and response in a timely manner and that risk and safeguarding issues are identified and addressed at first contact.

Whilst these developments are not a direct result of this review they should ensure that services are in a strong position to respond to similar cases in the future.

5. Conclusions and Recommendations

5.1 Conclusion 1

The review found no evidence that Elizabeth had been subject to physical abuse or wilful neglect during the period under review.

It is evident there was a lack of professional curiosity in relation to the impact that the relationship between Elizabeth and her sons may have had on her.

It remains unclear as to whether Elizabeth, on every occasion known to the review and on a day to day basis, willingly allowed her sons to access her finances. It is however evident that professionals exercised insufficient professional curiosity into potential coercion and control in this context.

The review recognises the complexities of the relationship between Elizabeth and her sons. The nature of the relationship between the sons appears at times to be turbulent and adversarial and there is no doubt that Elizabeth appeared to struggle with these complex relationships.

The review poses the probability that Elizabeth's decision making regarding financial matters would have been compromised by these relationships, and that Elizabeth may have felt some pressure to allow either one (or both) of her sons to access her money and make financial decisions on her behalf.

Whilst Elizabeth was deemed to have capacity to make these decisions, it remains unclear whether they were made with objectivity and without coercion. It is also possible that Elizabeth had 'fluctuating capacity'. In this context, professionals did not give sufficient consideration to Elizabeth's overall vulnerability and that this may have heightened her risk in relation to financial exploitation.

5.1.1. Recommendation

Agencies should assure the SAB that they have a clear understanding of all forms of potential abuse and the inter-relationship between them.

Agencies should assure the SAB that they are engaged in work across the partnership to strengthen pathways to safeguard adults who may be subject to abuse in all its forms.

5.2 Conclusion 2

Elizabeth received a number of assessments in relation to her capacity to make decisions. At each of the assessments, some of which were decision specific and in line with guidance contained in the Mental Capacity Act, Elizabeth was deemed to have capacity to make such decisions.

However, capacity decisions were not always conducted in the context of other vulnerability factors and it would have been useful to convene a multi-agency discussion to review Elizabeth's overall vulnerability, with a view to professionals taking safeguarding action as appropriate. A multi-agency overview of Elizabeth's risks and vulnerabilities would have been beneficial and the absence of multi-agency working is apparent in the case.

It is evident that Elizabeth sometimes neglected her own needs (e.g. not attending specialist health appointments). It is not possible for the review to comment on why this was the case, however, the review noted that Elizabeth was diagnosed with alcohol related dementia and that this may have impacted her perception of her own health needs.

More robust information sharing and stronger multi-agency working would have assisted professionals in understanding and responding to Elizabeth's risks and vulnerabilities, including those related to self-neglect.

5.2.1. Recommendation

Agencies should assure the SAB that the principles of 'Making Safeguarding Personal'[4] are applied in practice. Agencies should also assure the SAB that their practitioners have the necessary knowledge and skills to identify and respond to self-neglect.

5.2.2. Recommendation

Agencies should assure the SAB that all practitioners are engaging in multi-agency working, including case management discussions and multi-agency meetings.

5.3. Conclusion 3

The review found that safeguarding alerts (which were made from a number of sources) were not appropriately actioned on every occasion.

The review questions whether the volume of safeguarding alerts in this case, is an indication of professional uncertainty regarding the best way to respond to risks and vulnerabilities, and that making safeguarding referrals may have given professionals a false sense of security.

5.3.1. Recommendations

Agencies should assure the SAB that staff understand that raising a safeguarding alert does not replace the need to take safeguarding action.

Agencies should assure the SAB that safeguarding alerts are appropriately actioned and that historical evidence and events are taken into consideration when making decisions with regard to closure.

Agencies should assure the SAB that these decisions are, wherever practicable, discussed with the person concerned and with the referring agency.

5.4 Conclusion 4

A lack of consistent multi-agency working in the case led to inconsistency in understanding Elizabeth's risks and vulnerabilities. There was no shared approach to risk assessment or risk management.

5.4.1. Recommendation

The SAB should be assured that there is a shared understanding of risk and vulnerability between local agencies that leads to appropriate assessment, referral, escalation and de-escalation.

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[4] https://www.scie.org.uk/care-act-2014/safeguarding-adults/safeguarding-adults-boards-checklist-and-resources/making-safeguarding-personal.asp

GLOSSARY OF TERMS

Appointee-ship:	https://www.gov.uk/become-appointee-for-someone-claiming-benefits
ASC:	Adult Social Care
Care Act (2014):	http://www.legislation.gov.uk/ukpga/2014/23/enacted
Carer's Assessment:	https://carers.org/article/carers-assessment
Carer's Allowance:	https://www.turn2us.org.uk/Benefit-guides/Carer-s-Allowance/What-is-Carer-s-Allowance
CCG:	Clinical Commissioning Group
Domestic Abuse:	https://www.gov.uk/guidance/domestic-abuse-how-to-get-help
GMP:	Greater Manchester Police
GP:	General Practitioner

Making Safeguarding Personal: Making Safeguarding Personal https://www.scie.org.uk/care-act-2014/safeguarding-adults/safeguarding-adults-boards-checklist-and-resources/making-safeguarding-personal.asp

Mental Capacity Act (2005): https://www.scie.org.uk/mca/introduction/mental-capacity-act-2005-at-a-glance

NWAS:	North West Ambulance Service
SAB:	Safeguarding Adults Board
SAR:	Safeguarding Adults Review
STRIVE:	https://stockporttpa.co.uk/2018/06/26/tapiwa-dziruni-on-the-strive-project/